Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL
750 12TH AVENUE
FORT WORTH TX 76104

Respondent Name
Sparta Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3375-01

MFDR Date Received
July 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services. The services were denied due to prior authorization required but not requested."

Amount in Dispute: $29,064.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Notice of medical fee dispute was acknowledged however, no response was submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2012	Outpatient Hospital Services	$29,064.44	$29,064.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 19, 2012
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL "NOTE" BELOW. PRIOR AUTHOIRZATION REQUIRED BUT NOT REQUESTED.

Explanation of benefits dated April 5, 2012

- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- 270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY

Issues

1. Did the respondent support the insurance carrier's reason for denying disputes services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services billed for dates of service January 11, 2012 with reason code "16" "Claim/service lacks information which is needed for adjudication", and "270", "No allowance has been recommended for this procedure/service/supply please see special "Note" below. PRIOR AUTHORIZATION REQUIRED BUT NOT REQUESTED." Review of the submitted documentation shows prior authorization was obtained December 7, 2011 for the date span 01/4/2012 to 02/05/2012 under reference number 67138 for Insertion of programmable Spinal Drug Infusion Pump Inthrathecal Pump Replacement and Fluoroscopy Guidance. Therefore, the insurance carrier's denial is not supported. These services will be reviewed per applicable rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $11,350.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 62362 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0227, which, per OPPS Addendum A, has a payment rate of $13,514.89. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,108.93. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $7,708.35. The non-labor related portion is 40% of the APC rate or $5,405.96. The sum of the labor and non-labor related amounts is $13,114.31. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.21. This ratio multiplied by the billed charge of $7,371.00 yields a cost of $1,547.91. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $13,114.31 divided by the sum of all APC payments is 99.35%. The sum of all packaged costs is $769.77. The allocated portion of packaged costs is $764.78. This amount added to the service cost yields a total cost of $2,312.69. The cost

of these services exceeds the annual fixed-dollar threshold of $1,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $13,114.31. This amount multiplied by 200% yields a MAR of $26,228.62.

- Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code L8699 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code 82947 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.56. 125% of this amount is $6.95
- Procedure code 84132 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $6.51. 125% of this amount is $8.14
- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. These services are classified under APC 0272, which, per OPPS Addendum A, has a payment rate of $88.21. This amount multiplied by 60% yields an unadjusted labor-related amount of $52.93. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $50.32. The non-labor related portion is 40% of the APC rate or $35.28. The sum of the labor and non-labor related amounts is $85.60. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $85.60. This amount multiplied by 200% yields a MAR of $171.20.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   - "PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED" as identified in the itemized statement and labeled on the invoice as "KIT 8578 PUMP REV SEGMENT US (TRAY)" with a cost per unit of $150.00;
   - "PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED" as identified in the itemized statement and labeled on the invoice as "PUMP 8637-20 SM2 20ML EMAN US " with a cost per unit of $11,200.00.

   The total net invoice amount (exclusive of rebates and discounts) is $11,350.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,015.00. The total recommended reimbursement amount for the implantable items is $12,365.00.

5. The total allowable reimbursement for the services in dispute is $38,783.66. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $29,064.44. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $29,064.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $29,064.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 20, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
		June 20, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.